Islamophobia and Public ealth in the United States

Goleen Samari PhD MPH MA

Anti-Muslim sentiments are increasingly common globally and in the United States. The recent rise in Islamophobia calls for a public health perspective that considers the stigmatized identity of Muslim Americans and health implications of Islamophobic discrimination. Drawing on a stigma, discrimination, and health framework, I expand the dialogue on the rise of Islamophobia to a discussion of how Islamophobia affects the health of Muslim Americans. Islamophobia can negatively in uence health by disrupting several systems—individual stress reactivity and identity concealment), interpersonal social relationships and socialization processes), and structural institutional policies and media coverage). Islamophobia deserves attention as a source of negative health outcomes and health disparities. Future public health research should explore the multilevel and multidimensional pathways between Islamophobia and population health. *Am J Public Health* 2016;106:1920 1925. doi:10.2105/AJPH.2016.303374)

We cannot turn against one another by letting this ght be de ned as a war between America and Islam.

—*President Barack Obama*

Fueled by the ongoing crisis in Syria, the recent attacks in Paris, San Bernardino, and Brussels, and anti-Muslim rhetoric from politicians, anti-Muslim sentiments have been rising.[1,2] Hate crimes against Muslims in the United States remain 5 times more common than before September 11, 2001 (9/11), and although overall hate crimes in America dipped in 2014, anti-Muslim hate crimes rose by 14 over the prior year.[1] Islamophobia—a hatred of Islam or a stigmatization, fear, and dislike of Muslims—is pervasive.[3] From the 2015 Chapel Hill, North Carolina, shooting of 3 Muslims[4] to Ahmed Mohamed s removal from school because of his "bomb" clock,[5] we repeatedly see examples of Islamophobia, yet as public health researchers we pay little attention to the health implications of Islamophobia.

Islam is the world s second largest religion.[6] Estimates of the US Muslim population, which vary widely, average around 3.3 million, a gure that includes equal numbers of African Americans, South Asians, and Arabs.[7] By 2050, Muslims will be the second largest faith group in the country.[6] Islam has grown rapidly in the United States because of high rates of immigration, births, and conversions.[6,7] The past 2 decades, 15 of 22 Middle East countries have had prolonged conflicts, leading to large numbers of displaced individuals—many of whom are Muslims. However, Muslim Americans are of varied nativity and a third are third generation or higher, indicating a long history in the United States.[7]

Parallel to the growth of the number of Muslim Americans, Islamophobia has been increasing.[3] Muslims have been harassed on college campuses, mosques have been vandalized and defaced, Muslim charities have had their assets frozen, and racial pro ling has occurred at airports and on the streets.[1,8] The marginalization of Muslim Americans challenges health equity and may have important health implications. Important questions remain—how has the climate of Islamophobia in the United States affected the health of the growing population of Muslim Americans, and how does a public health understanding of health and disease help explain the relationship between Islamophobia and health?

CONCEPTUALIZING ISLAMOPHOBIA IN THE UNITED STATES

The word Islamophobia rst appeared in academic discourse in 1997 in a report by the Runnymede Trust, which de ned the construct as "unfounded hostility towards Islam and a fear or dislike of all or most Muslims."[9(p5)] However, Islamophobia denotes more than hostility; it reflects a history of US policy and discriminatory practices that enforce racial and xenophobic boundaries around Muslims.[10,11] Islam was an aspect of early US racism and was connected to the transatlantic slave trade—Americans were using the fear of Islam as a unifying concept to de ne what it means to be American.[12] For example, until 1944, American courts denied citizenship to those perceived or feared to be Muslim or of Muslim ancestry, some of whom were Christians.[12]

After the Iranian Revolution in 1979, US media coverage of Muslims became increasingly negative, which heightened discriminatory attitudes.[13] In the 1980s, stereotypical images of the "terrorist" were applied to Middle Eastern communities, including Muslims and Sikhs.[8,11] In 1996, the Antiterrorism and Effective Death Penalty Act led to investigation of Muslim American social activity and to the deportation of Muslims with links to terrorist activity.[11] These laws and media coverage form

BOUT THE UTHOR

Goleen Samari is with the Population Research Center University of Texas at Austin.

Correspondence should be sent to Goleen Samari PhD MPH MA Population Research Center University of Texas at Austin 305 E 23rd St Austin TX 78712-1699. Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

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a foundation of structural Islamophobia. In the United States, Islamophobia is conceptualized as social stigma toward Islam and Muslims, dislike of Muslims as a political force, and a distinct construct referring to anti-Muslim stereotypes, racism, or xenophobia.[3,8] Such a de nition illustrates how Islamophobia can affect public health at individual, interpersonal, and structural levels.

In a poll taken directly after 9/11, 60 of Americans reported unfavorable attitudes toward Muslims.[2] Many Americans associate Muslims with fear-related terms such as violence, fanatic, radical, war, and terrorism.[2,6] Public opinion poll research, media coverage, and government crime data suggest that Islamophobic sentiment sharply rose after 9/11, leveled off in the late 2000s, and steadily increased after the 2010 Ground Zero mosque controversy.[1,2,14] The media covered a lot of the protests and opposition to building a mosque close to Ground Zero. Any media exposure to Muslim-related issues is associated with a spike in negative attitudes toward Muslim Americans.[13]

In 2015, unfavorable attitudes toward Muslim Americans rose to a high of 67 .[2] Hate speech and crimes against Muslim Americans are commonplace.[1,14] Since the November 13, 2015, attacks in Paris, France, the Council on American–Islamic Relations reports a spike in threats, violence, and discriminatory acts, such as denial of employment and targeting of Muslim Americans (or those perceived to be Muslim).[14] Opposition to Muslim Americans is freely expressed, including policies for pro ling Muslims and a presidential campaign in which a candidate proposes a "ban on Muslims," forcing Muslims to navigate a sociopolitical landscape that views them as outsiders.

LINKING ISLAMOPHOBIA TO HEALTH

From a public health perspective, the social climate of Islamophobia in the United States is a risk factor for poor health. Islamophobia includes several known social processes that lead to adverse health outcomes. Speci cally, Islamophobia includes stigma and discrimination, which are known fundamental causes or determinants of adverse health.[15,16]

Stigma and Health

Stigma is de ned as the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a context in which power is exercised.[15] Stigma operates at multiple levels, including the individual, interpersonal (e.g., discrimination, hate crimes), and structural (e.g., community norms, institutional policies).[17] A stigmatized status affects health by undermining or exacerbating several processes—such as stress, the availability of resources, social relationships, and psychological and behavioral responses—that can lead to adverse health outcomes.[15] Members of stigmatized groups often lack the necessary resources to act on health knowledge.[18] Stigma can also trigger bias, which leads to unequal access to health-enhancing resources or medical care. Structural stigma is also associated with suicide, greater violence and homicide, and cardiovascular disease.[17]

As with other forms of stigma associated with HIV status, sexual orientation, or race, stigma experienced by Muslim Americans involves labeling, stereotyping, status loss, and discrimination. The stigmatized identity of Muslims was initially brought into focus by Edward Said s *Orientalism*,[19] which noted the Western perspectives that created a dehumanizing representation of the exotic and barbarous Orient (countries of the Middle East, Africa, and Asia) that exists in opposition to the West. Islamophobia is rife with stereotypes of Muslim Americans and Americans who look "Muslim-like," from those pertaining to Muslim women and the veil to the assumption that all Muslim men are terrorists.[20] The spread of Islamophobia has further sanctioned dehumanizing representations and stereotypes of Muslims in the United States, solidifying the construction of a stigmatized Muslim identity.[21] Islamophobia operates as stigma through individual identity concealment, interpersonal experiences of discrimination and hate crimes, and structural conditions such as immigration policies targeting Muslim immigrants.[8,11,21,22] For example, Muslim Arab Americans in New York City after 9/11 noted that they feared hate crimes and had anxiety about future threats to their safety, loss of community, isolation, and stigmatization.[23]

Discrimination and Health

Discrimination at interpersonal and structural levels is a constitutive feature of a stigmatized identity. The Muslim American discriminatory experience is likely a combination of appearance-based and religious discrimination.[24] An established body of research documents the link between discrimination and health.[16,18,25] Across multiple contexts, perceptions of unfair treatment, regardless of whether they are attributed to race or other social reasons, are adversely related to physical and mental health[16,18,26] and health disparities.[25]

A 2015 review by Paradies et al.[26] found that everyday experiences of discrimination are also associated with a wide variety of physical and mental health outcomes, such as coronary artery calci cation, high levels of C-reactive protein, high blood pressure, giving birth to low-birth-weight infants, cognitive impairment, poor sleep, visceral fat, depression, psychological distress, anxiety, and mortality, as well as risk factors for poor health such as substance abuse. Discrimination affects health through pathways including reduced access to resources and increased exposure to risk factors, stress, physiological processes, allostatic load, reduced participation in health care–seeking and health-promoting behaviors, and violence.[26]

Racial/ethnic discrimination of Muslim Americans. The relationship and magnitude of the effects of discrimination on health are known to vary by racial and ethnic groups,[27] highlighting the importance of group membership. De ning the group context of Islamophobia is challenging, as Islamophobia includes discrimination based on race, nativity, physical appearance, and religion. Islamophobia both results from and contributes to the construction of race or socially constructed categories of individuals physical appearance in the United States.[11,28]

Because Muslims are often represented as coming from non-White groups, their religious identity becomes linked with racial identity. As racism, Islamophobia affects the lives of people with "Muslim-like" appearances in the United States. But who exhibits "Muslim-like" appearance? It extends

beyond race to include such attributes as clothing. Having a certain skin tone, wearing a hijab or turban, and speaking with a certain accent are all physical markers that create a vulnerability to Islamophobia; however, non-Muslims such as Christians and Sikhs can also have these characteristics.[11] In the Detroit, Michigan, Arab American community, which includes both Muslims and Christians, increased psychological distress, lower levels of happiness, and poorer perceptions of health status are associated with post-9/11 abuse and discrimination.[29,30]

Middle Eastern Americans are most often assumed to have "Muslim-like" appearances and are thus exposed to Islamophobia. While they are classi ed as "White" by the Of ce of Management and Budget, they do not bene t from White privilege and are still exposed to Islamophobia based on physical appearance.[10] In reality, they come from many different countries of the Middle East and North Africa[30] and include many different nationalities, religions, and racial categories, including Black and White.

One race does not t all for the relationship between discrimination and health outcomes,[27] and Islamophobia does not affect individuals from 1 racial category—it spans racial groups, including those classi ed as White. Muslims who identify as non-White and reside in an ethnic enclave report more discrimination than Muslims who identify as White, but Arab Americans who identify as White experience more discrimination-associated psychological distress.[30] Given the racial diversity of Muslim Americans, pathogenic conditions of Islamophobia have to be understood across racial groups.

Religious discrimination of Muslim Americans. Islamophobia as a form of religious discrimination may coexist with or override racial and appearance-based discrimination, such that religious identi cation may precede, overlap, or follow race as a basis for discrimination.[31,32] However, a review by Padela and Curlin[24] notes that there is far less research on the health effects of religious discrimination. A study from the United Kingdom indicates that racism and religious discrimination form distinct measures. Ethnic Pakistani, Indian, Bangladeshi, White, Other Asian, Black, Arab, and mixed race Muslims are equally likely to record speci c discriminatory experiences.[31]

Religion can unite individuals from disparate racial, ethnic, and socioeconomic categories.[22,24] About 69 of Muslims in the United States say that religion is very important in their lives.[6] Although diverse, the Muslim American community could share a religious worldview that can influence health-related behaviors and interactions with the health care system.[32] Islamic tenets—such as abstention from drinking alcohol and the belief that "physicians are actors of God" and that all Muslims should regularly receive medical care—can promote health.[33,34] Religious discrimination alienates individuals from the health system, directly interfering with health messaging in Islam that promotes disease prevention and care seeking.[22,24]

However, as with other religions, Muslim Americans follow a range of Islamic and personal religious beliefs, so discriminatory assumptions can also interfere with health care. For example, in a qualitative study of Iraqi refugees, participants described health care providers as unhelpful, patronizing, and having stereotypical attitudes toward Muslim women—believing they are excessively pious, have too many children, and are oppressed by their husbands.[35] Religious discrimination is hypothesized to lead to stress, social isolation, reductions in health-promoting behaviors, discounting of health care providers information, and delays in seeking medical care.[24]

Multilevel Pathways to Health

Research on stigma, discrimination, and health shows that Islamophobia can have a negative influence on health through the disruption of several different systems—individual (stress reactivity and stereotype threat), interpersonal (social relationships and socialization processes), and structural (institutional policies and media coverage). Although it is not based on an exhaustive literature review of the health of Muslim Americans, this section shows how Islamophobia includes many individual, interpersonal, and structural processes that are known determinants of health.

At the individual level, Islamophobia increases stress among Muslim Americans.[29] Stress can play a role in the onset, progression, and severity of illness.[16] Social marginalization increases stress, the physiological response to stress—including higher blood cortisol and heart rates—and the health-diminishing effects of that response over time.[36] This continuous activation of the allostatic system wears out regulatory systems. Discrimination of Muslim Americans has been linked to stress-related outcomes such as paranoia and psychological distress.[29,37] More than 50 of Muslim youths in the United States report experiencing bullying in schools.[14] This early exposure to discrimination is likely to have cumulative health effects over the life course.[36]

Stereotype threat—the activation of negative stereotypes among stigmatized groups, which creates expectations and anxieties that can adversely affect social and psychological functioning[18]—can also contribute to stress.[38] Stigmatized individuals become aware of and react to societal stereotypes.[38] Stereotype threat can negatively affect physiological, psychological, and self-regulatory processes that contribute to poor health.[38] Furthermore, young Muslim American men have been found to hide their identities.[21] Muslim Americans could also experience negative health outcomes from identity concealment or internalizing Islamophobic stereotypes.[39] For example, in a qualitative study, Muslim Arab American immigrant women note that wearing the hijab leads to discrimination, which takes a toll on their physical and mental health.[34]

At an interpersonal level, Islamophobia-based stereotype threat can adversely affect the patient–provider relationship by producing impaired communication, discounted provider information, or failure to obtain medical care.[38] In a qualitative study, Muslim immigrant women expressed discomfort with their health care providers.[40] Muslim Americans may fear obtaining services or feel misunderstood by health care providers.[33] In general, Islamophobia affects interactions with the health care system and prevents individuals from accessing preventative health services.[33]

Stigma is also known to cause social isolation.[15] Islamophobia deprives American Muslims of the health-promoting aspects of social connection, creating an environment of limited social ties and thus increased

vulnerability. Muslim Americans are fully aware of their devalued position in society.[20,21] Hostility in the public arena makes it dif cult for Muslim Americans to develop a community life. Muslim American youths even police each other within their own communities.[21] Research has suggested that identity-af rming networks can buffer the adverse effects of discrimination on health.[41] In general, social support and social networks promote physical and mental health.[42] A lack of social support has been linked to depression among Arab Muslim immigrant women.[43] However, Arab Muslims who associate with identify-af rming networks have more psychological distress.[30] Identifying as Muslim in our current sociopolitical context is more of a stressor than an avenue for social support and so is more detrimental than protective for health.

Islamophobia can also produce health disparities through structural stigma at the macro level. Although research on structural stigma of Muslim Americans and health is limited, 1 study found that in a period of heightened stigma following September 11, 2001, pregnant women of Arab descent had poor birth outcomes.[44] Discriminatory ideologies in the structural features of institutions, policies, and media coverage can create or reinforce health disparities.[25] For example, the 2001 Patriot Act and associated legislation gave the state new powers, including surveillance, which pro les Muslim Americans or "Muslim-like" Americans, contributing to social segregation and differential access to resources for Muslim Americans.[11] Immigration policy also contributes to structural inequity and social segregation.[25] There is a pattern of racial and religious pro ling in the naturalization process to block citizenship of individuals from Muslim countries.[8,12] In addition to these discriminatory policies, the media also shape the structural social environment of Muslim Americans in ways that can affect health. Negative media coverage of Muslims plays an active role in social understanding of Muslims as "the enemy" and in perpetuating Islamophobia.[13] Such structural factors as exclusionary policies and media coverage can lead to differential access to fundamental determinants of health such as education and employment, limit access to health and social services, and contribute to experiences of discrimination, stress, and illness.[18,25]

RESEARCH DIRECTIONS

Given the expanding climate of Islamophobia and the link between Islamophobia and social determinants of health, there are several promising research directions. Public health scholars can take steps to better understand and address the health disparities that Muslim Americans face in the United States.

Despite a large body of research on discrimination and health, the virtual absence of an established literature on Islamophobia and health is striking. What studies exist tend to focus on mental health, showing adverse mental health outcomes for Muslim Americans.[22–24,29,30,37] Research on Islamophobia and physical health outcomes is extremely limited. However, 1 study linked structural stigma toward Arab Americans to poor birth outcomes,[44] and a brief review of Muslim American health by Padela and Raza found disparities in cancer and reproductive health.[32] Although both the physical and mental health consequences of Islamophobia are important areas for future inquiry, more research on such Islamophobia and physical health outcomes as cardiovascular disease, cholesterol levels, body mass index and other measures of obesity, and diabetes is needed. Research is also needed on the mental and physical health effects of Islamophobia for Muslim men and women, as research tends to focus on Muslim American women.[40,43,44]

The lack of health literature on Islamophobia makes it dif cult to assess its incidence and to understand multiple sources of discrimination for Muslims in the United States. Islamophobia is an opportunity to examine the health effects of the intersection of several forms of discrimination.[22] Muslims vary by race, ethnicity, national origin, social class, gender, and immigration status. Any or all of these identity constructs can be sources of social bias, and attaining an accurate picture of risk requires considering all sources of social bias.[45] Generally, inadequate research attention is given to the ways in which racism combines with multiple aspects of stigma and discrimination, additively and interactively, to affect health.[18] Padela and Raza suggest that more research on Muslim Americans is needed to disentangle the independent influences of religion, race, and ethnicity on health disparities.[32] Future research should also unpack the effects of physical appearance, immigration status, and gender or the intersection of these constructs as sources of discrimination. To better understand Islamophobia and health, studies should focus on the experience of those affected and pose questions about both racial and nonracial discrimination experiences. Asking about different dimensions of discrimination, such as religious attire and immigration status, may capture more of the pathogenesis of Islamophobia. Religion may act in conjunction with immigration status, race, or gender as a basis for discrimination for this population. Multigroup analyses could also help elucidate the effects of race, nativity, physical appearance, and religion.

The effects of moderators and mediators for stigma, discrimination, and health remain largely unknown and are not uniform across groups.[15,18] Important research directions should include understanding the role of behavioral responses, stress, social isolation, stereotype threat, identity concealment, and access to resources on the pathway between Islamophobia and health. For example, the relationship between Islamophobia and health could operate through discrimination-associated stress for a Muslim American woman who wears a hijab and through stereotype threat and identity concealment for a Muslim American male who tries to conceal his Muslim identity. Is one pathway more damaging than another? Are the different aspects of Islamophobia multiplicative for health? Further research is needed on whether certain pathways and levels of Islamophobia-driven stigma are more or less damaging for physical and mental health. It is also important to explore how Islamophobia affects socialization, and how socialization experiences and coping strategies in response to Islamophobia may modify the relationship between exposure to Islamophobia and health. Identifying these pathways and conceptual links can provide further insights into how to prevent the health-damaging effects of Islamophobia.

The research to date has typically considered the experience of Islamophobia at the individual level. Structural stigma and

racism remain understudied.[17,25,45] Therefore, less attention has been paid to how societal conditions (e.g., institutional policies) may disadvantage Muslim Americans. Islamophobia and health have to be understood and addressed at the structural level, where stigmatization is produced and can set in motion such pathways as lack of social support.[15] For example, does living in a Muslim American community buffer some of the effects of Islamophobia? Does living in a more Islamophobic community have detrimental health effects? It would be important to understand whether living in areas with more structural barriers—such as negative media coverage, policies against building mosques, or the presence of fewer Muslim Americans—is associated with negative health outcomes. Comparisons between the United States and European countries could also offer insights into the relationship between structural Islamophobia and health. Empirical research should span multiple levels of analysis to fully capture the way Islamophobia operates to shape population health.

This research agenda is not without challenges and limitations. The first challenge is identifying Muslim Americans within existing health care databases and survey data. Researchers can only identify people who are likely to be Muslim, which in the United States usually means those of Middle Eastern or South Asian descent. However, a large proportion of Arabs are not Muslim—many are Christian.[7] Although both Middle Eastern Americans and Muslim Americans can experience Islamophobia, we should be careful not to conflate the 2 groups.[11] We need to collect survey data that enable us to disentangle associations between religious group membership experiences and health outcomes.

For researchers to consider the role of Islamophobia in the production and maintenance of health disparities, they need data that measure multiple dimensions of Islamophobia and Muslim identity. This would provide further insights into the relationship between stigmatized identities, discrimination, and health disparities. In health research, the Perceived Religious Discrimination Scale and measures of religious discrimination in health care have been developed for use with Muslims.[24,37] However, measures that include several dimensions of Islamophobia-driven discrimination and implicit bias, as well as the threat of Islamophobia, are needed. Data that include measures of Islamophobia over the life course and Islamophobic social environments can help assess variation among social groups.[3] Longitudinal studies should gather information about Islamophobia over time and how it is influenced by social changes.

A third challenge is developing appropriate theoretical and conceptual models to help explain health outcomes among Muslim Americans. Given the unique interaction of multiple marginalized identities in this population, we need to be mindful of developing population-appropriate conceptual frameworks to explain Muslim American health. Failure to consider both the multilevel stigmatizing and discriminatory aspects of Islamophobia in theoretical models of population health leads to an underappreciation of aspects of Islamophobia that produce poor health.

The current climate of Islamophobia and the research on stigma, discrimination, and health suggest that greater attention needs to be paid to Islamophobia and public health in the United States. Islamophobia likely exerts a greater impact on population health than research to date suggests. Future public health research should explore the multilevel and multidimensional pathways linking Islamophobia to population physical and mental health. AJPH

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